



## ***Texas Department of Insurance***

### ***Division of Workers' Compensation***

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## ***MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION***

### ***GENERAL INFORMATION***

#### **Requestor Name and Address**

DEC OF TEXAS, INC.  
601 TEXAN TRAIL SUITE 201  
CORPUS CHRISTI, TEXAS 78411

#### **Respondent Name**

FEDERAL INSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 17

#### **MFDR Tracking Number**

M4-12-0481-01

### ***REQUESTOR'S POSITION SUMMARY***

**Requestor's Position Summary:** "Claimant was scheduled for DDE which too place back on March 08, 2011 and as of today's date payment has not been received. Bill has been submitted on 2 separate occasions to no avail. Requesting your assistance in getting balance paid as well over 180 days. Also requesting that interest be paid as my office submitted bill on more than one occasion and insurance company still has not processed."

**Amount in Dispute:** \$500.00

### ***RESPONDENT'S POSITION SUMMARY***

**Respondent's Position Summary:** A copy of dispute was placed in carrier rep box on October 17, 2011 with no response to MFDR.

**Response Submitted by:** NA

### ***SUMMARY OF FINDINGS***

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 08, 2011	Table states 99456-WP-RE CMS1500 states 99456-W5-RE	\$500.00	\$500.00

### ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

## **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:  
No Explanation of Benefits was provided by either party to the dispute.

## **Issues**

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

## **Findings**

1. The requestor billed the amount of \$650.00 on the CMS-1500 for CPT code 99456 with modifiers –W5 and –RE for Division ordered DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). The Table of Disputed Services lists 99456 with modifiers –WP and –RE with a billed amount of \$500.00. It is noted that –RE is not an appropriate modifier for use with this billing and that a key modifier is missing on the bill submitted with the DWC-60 packet. There is no indication that any attempt to correct this modifier was made. However, as there are no explanations of benefits nor response to MFDR DWC-60 with any objections to modifier usage, MFDR will review this dispute per the documentation of the services performed. Review of the documentation supports that the doctor assigned MMI as requested by DWC. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is \$350.00. Also, an IR was performed per the request of DWC. Documentation states that the AMA Guides to the Evaluation of Permanent Impairment, 4<sup>th</sup> Edition guides were used. Range of motion (ROM) IR testing was done to right wrist (upper extremities per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a) with a MAR of \$300.00. The combined MMI/IR MAR is \$650.00.
2. Respondent has not paid any amount on the billed CPT code 99456-W5-RE, therefore the disputed amount of \$500.00 is recommended.

## **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$500.00.

## ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

## **Authorized Signature**

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Signature

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Medical Fee Dispute Resolution Officer

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March 09, 2012  
Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**